A BLUEPRINT FOR IMPROVING RENAL SERVICES IN NEW ZEALAND

Chronic Kidney Disease (CKD) is a common health issue that affects one in eleven New Zealanders. Approximately 4000 New Zealanders have end-stage kidney disease (ESKD), and this number is increasing by 5% each year. The prevalence of treated dialysis and transplanted patients (forms of Renal Replacement Therapy – “RRT”) has risen by 250% over the last 15 years.

Expenditure on RRT accounts for between 1 to 2 percent of the total public health expenditure. Dialysis currently costs New Zealand over $150 million each year, and is approximately 3 times more expensive than transplantation on a per patient per year basis.

The current Government is to be congratulated for increasing the focus on renal disease, especially its focus on initiatives to increase live renal transplantation. Yet there are further opportunities to both increase the quality of services to renal patients and reduce costs in the health sector – renal disease is one of the few sectors in the health system where better services means lower costs. This attached blueprint sets out Kidney Health New Zealand’s proposals for better and lower cost renal services in New Zealand.

Members of KHNZ would welcome the opportunity to discuss our blueprint with you in person, to explain the elements of the blueprint and how they could be factored into policy development in the run-up to the election.

About KHNZ

Kidney Health New Zealand (KHNZ) is an independent national organisation that is:

- The national voice for people with chronic kidney disease, and their families, and
- The primary source of reliable and relevant information on the prevention and management of kidney disease in New Zealand.

KHNZ’s stakeholders include people with kidney disease, their families and supporters; kidney health professionals; researchers and 22 independent regional kidney patient support organisations.
KHNZ’s Blueprint

Our blueprint for better and lower costs services to renal patients in New Zealand includes:

1. Address the low rates of deceased renal transplantation. New Zealand’s rate of deceased renal transplantation is amongst the lowest in the Western world; being amongst the best would lead to about an extra 100 transplants in New Zealand a year. We propose establishing a Ministerial enquiry to identify how the world’s best practice can be applied to New Zealand.

2. Facilitating pre-emptive live transplants. While health professionals accept the benefits of pre-emptive transplantation (that is, undertaking a transplant - if possible - before starting dialysis), there is variation in practice across the country with a range of <10 to 45 percent of all live donor transplants being carried out pre-emptively. We propose setting a KPI for the new National Renal Transplantation Service for pre-emptive transplantation at 45% - the NZ benchmark - and develop methods for providing a financial incentive for DHBs to increase pre-emptive transplantation.

3. Reimbursement of live donors’ expenses. New Zealand currently only reimburses donors for lost income to the level of the Sickness Benefit – up to $335/week. This amount does not meet the national median mortgage costs of over $400/week, let alone other living and medical expenses incurred post-discharge. We propose that a programme be developed to fully re-imburse the costs (including loss of income) for live kidney donors be developed by the Ministry of Health based on the Financial Assistance for Live Organ Donors Bill. The costs of this programme would be met from the underspent existing appropriation in the Ministry of Social Development.

4. Reducing barriers to home dialysis. Currently there are about 2,500 people on dialysis in New Zealand. Dialysis can be performed independently by the patient in their home, or undertaken in a dependent fashion by staff at a facility. Fewer New Zealanders are choosing home dialysis even though improving the uptake of home dialysis will increase the longevity and quality of life of dialysis patients, and reduce costs. We propose that the Government set a national target of at least 65% of dialysis patients on a community-based therapy and task the Ministry of Health to actively support the National Renal Advisory Board to develop national practice standards for home dialysis.

5. Improve support for home dialysis patients. Home dialysis patients take responsibility for their own dialysis and save about $30,000 annually each by not using more expensive hospital based dialysis. However patients and their carers report that they often feel unsupported and question why in some parts of the country out-of-pocket expenses, from $500 to $1,000 annually depending on the dialysis type, are not reimbursed by their DHB. We recommend that the Ministry of Health co-ordinate a stock take of DHB policies to reimburse home dialysis patients for out-of-pocket expenses, and develop policies to ensure that DHBs reimburse home dialysis patients.
6. Access to “Away from home” haemodialysis Patients on dialysis cannot take a break from treatment. This presents challenges when patients require haemodialysis treatment when they travel away from their base unit or home (if on home dialysis) for business or as part of their work. In many cases, this may mean that a patient has to change their job or stop working: neither outcomes are conducive to their full rehabilitation. Improved access to “away from home” dialysis would increase the opportunities for some dialysis patients to get a job. For all dialysis patients and their carers, difficulties in accessing holiday dialysis can lead to carer burnout and depression for haemodialysis patients. If patients and/or carers experience burnout they are likely to revert to more expensive and, for many who live distant from the renal unit, inconvenient, hospital dialysis. Holidays and other trips from home are an essential part of renal replacement therapy and the lack of this provision can have a detrimental effect on patient welfare and outcomes but there are issues with New Zealand renal units’ capacity to accept out of town patients and a lack of national co-ordination. KHNZ recommends that the Ministry of Health, in consultation with the NRAB and KHNZ, develop proposals for the Minister’s consideration on including provision of facilities for “away from home” dialysis (including holiday dialysis) as part of the standards of dialysis care.

7. Improve GP knowledge of management of CKD. Most CKD is managed in primary care. Most people with CKD do not know they have the condition. Early detection and treatment reduces the important complications of CKD – heart disease, kidney failure and premature death – by about 50%. But there is no national education programme for GPs and practice nurses. There is evidence of patchy performance by primary care in recognition and management of CKD. We recommend that the Ministry of Health develop a proposal for a national education programme on CKD management for primary care, including adopting and modifying the Kidney Check Australia Taskforce (KCAT) programme developed by Kidney Health Australia (KHA) for use in New Zealand.

The attached document sets out these proposals in more detail. Collectively, they will increase patient’s life expectancy and their quality of life. We commend them to you.

We look forward to hearing from you.

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A blueprint for Improving the effectiveness and quality of renal services in New Zealand

Chronic Kidney Disease (CKD) is a common health issue that affects one in eleven New Zealanders. Approximately 4000 New Zealanders have end-stage kidney disease, and this number is increasing by 5% each year. The prevalence of treated dialysis and transplanted patients has risen by 250% over the last 15 years.

People with CKD have increased risks of end stage kidney disease (ESKD), heart disease, hospital admission for any cause and death.

ESKD or kidney failure is irreversible severe kidney damage that leads to death in days to weeks without renal replacement therapy (RRT) by either dialysis or transplantation. About half the cases of new treated ESKD are caused by diabetes; other important causes are high blood pressure, nephritis and inherited kidney disease. Renal transplantation is the best form of RRT for those who are suitable and offers a longer life, let alone a better quality and economically more productive life, for patients compared to the alternative, dialysis. It is also more cost effective – the “payback” period for a renal transplant is less than two years compared to in-hospital dialysis.

A person can receive a transplant from a living or deceased donor.

Expenditure on RRT accounts for between 1 to 2 percent of the total public health expenditure. Dialysis currently costs New Zealand over $150 million each year, and is approximately 3 times more expensive than transplantation on a per patient per year basis.

The current Government has made a significant investment in improving one aspect of the renal services in New Zealand – live transplantation. There are further, inexpensive opportunities to improve patient outcomes and value for money in the health sector by reform in other parts of the renal service.

This blueprint sets out seven proposals to improve health, social and economic outcomes for renal patients and their families, while reducing costs for the health system.

These seven proposals relate firstly to further improving renal transplantation, and secondly to improving dialysis services.
STRENGTHENING RENAL TRANSPLANTATION

1. Deceased donation – address the low rates of deceased renal transplantation

What is the issue?

While NZ has excellent survival rates for deceased kidney transplants, it has low deceased donor rates when compared to countries with similar health systems:

![Graph showing deceased donation rates per million population](image_url)

While the current Government has made a significant investment in live transplantation – which is starting to have an impact on the ground in terms of services and supports for patients and medical professionals – there has been little change in the area of deceased renal transplantation. Recent increased Government funding, and additional staff training by the oversight body (Organ Donation NZ – ODNZ) have not made a material difference to this low rate and the waiting list for a kidney transplant continues to grow.¹

<table>
<thead>
<tr>
<th>Transplants in NZ (source: ODNZ)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tr>
<td>Live Donor</td>
<td>67</td>
<td>60</td>
<td>57</td>
<td>54</td>
<td>58</td>
</tr>
<tr>
<td>Total transplants</td>
<td>121</td>
<td>110</td>
<td>118</td>
<td>108</td>
<td>113</td>
</tr>
</tbody>
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Many consumers and health professionals are concerned that some families of potential deceased organ donors are overruling their wishes by refusing to allow their organs to be used. Although families do not have a right to object to donation, doctors often agree not to take organs to avoid dispute. These situations can be avoided where there had been a full family discussion about organ donation wishes during the life of the potential donor. The Australian Organ and Tissue Authority with the DonateLife Network, have promoted a programme to encourage such conversations.

A number of European countries have opt out, or presumed consent, legislation which considers all people are potential deceased donors after death unless they have registered not to be. The two types of organ donor regulation – opt in or out into – can be classified also as “pure” and “mixed” systems. In the “mixed” systems the family have the final say. New Zealand currently has a mixed opt in system.

In general, in countries where there is opt in legislation there are high living donation rates and in those with opt out legislation, high deceased organ donation rates. All countries are seeking renal services that have high rates of both deceased and life renal transplantation.

While the focus to date in the public debate has been about opt-in versus opt-out legislation, what is probably more important on the ground is how to organise the services that approach the families of potential donors. European countries have some of the highest deceased renal transplantation rates in the world – with Spain leading the way – and these systems have developed more sophisticated approaches to organising their services in hospital, and how they approach potential donors and their families. In particular:

- Early identification of potential organ donors by hospital staff and a culture that believes that organ donation is the normal thing to occur when a person dies.

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2 http://www.donatelife.gov.au/discuss
• Even though Spain has a presumed consent policy, it is not applied in practice by health professionals. ICU staff still approach the relatives to explain to them the patient’s health conditions and to find out whether the patient wanted to be an organ donor or not. If the relatives oppose donation, deceased organ donation does not proceed. As Spain has one of the lowest rates of deaths due to cerebrovascular diseases or traffic accidents in the Europe, one could presume that the process of requesting consent for donation from relatives is very effective.

• The Organisazión Nacional de Transplantes (ONT) was established in 1989 by the Ministry of Health to oversee donation and transplantation activities. At the same time a three level donor transplant network was setup - ONT coordinating all activities; regional networks; and the network of 181 organ procurement hospitals. These hospitals have specially trained donor-transplant coordination teams on-site. The teams, usually only part-time dedicated to organ coordination, consist of physicians and nurses and are ideally led by an intensive care doctor, something that facilitates the early identification of potential donors.

In other words, how services are organised and delivered can and does have a significant impact on deceased transplantation outcomes irrespective of the legislative approach.

Key elements of the “Spanish model” are being progressively rolled out over the rest of the European Union (EU). This model is becoming the benchmark for the delivery of deceased renal transplantation services across the world.

In New Zealand, the Medical Director of ODNZ is on record as denigrating the Spanish model, even though it is demonstrably successful offshore. There is no sign that the Board of ODNZ is actively progressing new options – rather deceased renal transplantation rates are lagging the rest of the world and is failing patients and their families.

*Why is it a problem?*

New Zealand’s failure to consider – let alone adopt – international best practice means New Zealand is not realising the potential for deceased renal transplantation. The result is that some renal patients are dying early, and un-necessarily. Achieving the rates of deceased renal transplantation of Spain and Portugal would result in up to 100 more deceased transplants a year in New Zealand.

*Recommended actions*

The issues identified above are complex, and need a broad conversation about the best mix of legislation and service improvements – building off international best practice from the EU and elsewhere. This is not a conversation that can be left alone to ODNZ – and to date they have not shown leadership on this issue.

This conversation should consider the potential for changes to legislation, the potential role of donor registers, and options for changing NZ service delivery in line with changes being made in the rest of the world.
KHNZ proposes a Ministerial enquiry into improving the rates of deceased renal transplantation in NZ, based on applying best international practice to NZ. We propose that the enquiry to be appointed in early 2015 and to report back to the Government within 6 to 9 months of establishment.

Estimated cost: $300,000 for the Ministerial Enquiry

This cost would be offset by the financial savings from the resulting extra deceased donor transplants.

2. Facilitating more pre-emptive live transplants

What is the issue?

Pre-emptive live donor kidney transplantation is the best treatment for ESKD for most people and avoids the costs of dialysis, at least initially. Pre-emptive live donor renal transplantation is associated with the best clinical outcomes of any form of kidney transplantation and avoids unnecessary and more expensive dialysis treatments.

A pre-emptive live transplant – costing about $90,000\(^3\) in its first year, not only leads to a longer life expectancy and the patient leading a full economic life, but is cheaper than the ongoing costs of dialysis of around $65,000 per patient annually (hospital-based dialysis costs) or home dialysis costs at around $35,000 annually.

While health professionals accept the benefits of pre-emptive transplantation, there is variation in practice across the country with a range of <10 to 45 percent of all live donor transplants being carried out pre-emptively. Through calls to our 0800 call service, KHNZ staff are aware that there is variation throughout the country in the amount and quality of information given to patients with ESRD by their DHBs about pre-emptive transplantation. Other reasons for low rates of pre-emptive transplantation are delays in donor work up and access to surgery.

Why is it a problem?

When kidney patients miss out on pre-emptive transplantation they have to start dialysis as the first treatment for ESKD with attendant extra costs and procedures and worse health outcomes.

Recommended actions

The Government has established a new National Renal Transplantation Service, with a particular focus on live transplantation. KHNZ recommends boosting the rate of pre-emptive live renal transplantation by

- Setting a KPI for the new National Renal Transplantation Service for pre-emptive transplantation at 45% - the NZ benchmark - and develop methods for providing a financial incentive for DHBs to increase pre-emptive transplantation

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The National Kidney Transplant Service should require that information on pre-emptive transplantation is included in all educational material available from DHBs and NGOs.

The National Renal Transplant Service be mandated to deliver a nationally consistent model for donor and recipient work-ups that addresses major inconsistencies in the approach to, and timeliness of, work-ups.

Estimated cost

Increasing pre-emptive transplants would save money over the long term, although there may be an up-front investment required to bring forward transplant costs.

3. Reimbursement of live donors’ expenses

What is the issue?

Some otherwise willing live donors delay or decline to donate due to potential loss of income, during the four to six weeks recovery following surgery. Recent research from Victoria University indicates that patients are reluctant to ask potential live donors because of the financial impact that being a donor would have on family finances.

The World Health Organisation’s Guiding Principles on Organ Transplantation⁴ and The Declaration of Istanbul on Organ Trafficking and Transplant Tourism⁵, for example, both confirm that reimbursement of lost income and medical expenses for donors is acceptable.

New Zealand currently only reimburses donors for lost income to the level of the Sickness Benefit – up to $335/week. This amount does not meet the national median mortgage costs of over $400/week, let alone other subsistence and medical expenses incurred post-discharge.

The Private Member’s Financial Assistance for Live Organ Donors Bill, proposes increased compensation to live organ donors, in line with ACC payments, to cover 80% of live donor lost income. This Private Member’s Bill was not drawn from the ballot in this term of Parliament.

Kidney Health New Zealand supports an increase in the level of compensation of costs to live donors.

⁵ The Declaration of Istanbul on Organ Trafficking and Transplant Tourism (http://www.declarationofistanbul.org/index.php)
Why is it a problem?

The current reimbursement for potential live kidney donors does not cover the actual costs of donation for many. Uptake of the existing programme has been low and transplant units still report that some people are deterred from considering live donation because of the loss of income involved, while others who do go ahead suffer financial hardship as a result of donation.

The WINZ administered Sickness Benefit programme does not cover the costs of live donors, is not customer friendly and WINZ staff are often unaware of its provisions.

Recommended Actions

There is an existing appropriation in the Ministry of Social Development for the current Sickness Benefit programme which has been consistently underspent (only $32,670 was spent in 2010; no updated information could be found in the 2014/15 Estimates) and this could be used to fund an increase in the level of compensation to those donors who would be out of pocket otherwise.

KHNZ recommends that:

- A programme be developed by the Ministry of Health to fully reimburse the costs (including loss of income) for live kidney donors based on the Financial Assistance for Live Organ Donors Bill.

- The Ministry of Health be directed to advise further on options for developing such a programme, including whether legislative change is needed or whether it could be introduced under the current Human Tissue Act (2008).

- The programme be developed as a health initiative, administered by the Ministry of Health, rather than as a welfare programme administered by WINZ.

- Re-imbursement be set at 100% of costs and lost income, and

- The costs of the new programme are met by transferring the annual funding from the Ministry of Social Development to the Ministry of Health.

Estimated cost

This programme would spend currently appropriated funding from the Ministry of Social Development budget. No new net fiscal cost expected.
**IMPROVING DIALYSIS AND PATIENT SERVICES**

4. Reducing barriers to home dialysis

*What is the issue?*

Currently there are about 2,500 people on dialysis in New Zealand. Dialysis can be performed independently by the patient in their home, or undertaken in a dependent fashion by staff at a facility.

Despite acknowledged health benefits and a strong need for cost containment, fewer New Zealanders are choosing home dialysis. Improving uptake of home dialysis will increase the longevity and quality of life of New Zealanders with ESKD, and reduce the costs of this expensive and sparse resource. Clinically, home dialysis is preferable since it is associated with greater survival and quality of life. Those on home dialysis also report better social integration and enhanced employment compared to those on facility dialysis.

Per patient, home dialysis is approximately half the cost of facility dialysis. While New Zealand has been a world leader in home dialysis - currently just over half of all dialysis is home based – this rate has fallen over recent years and there are concerns that it will fall further.

This is shown in the graph below. Note that “PD” refers to peritoneal dialysis, and “HD” refers to haemodialysis – alternative forms of dialysis:

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In some DHBs there is a lack of understanding of the benefits of home dialysis for patients and the health system and a paucity of staff expert in training and supporting patients on home dialysis. Where patients do not have home dialysis presented to them in clinics and education sessions as the optimal form of dialysis, uptake of home dialysis is comparatively low.\textsuperscript{12}

\textit{Why is it a problem?}

Patients who are not supported to do home dialysis miss out on the better clinical outcomes versus facility and hospital based treatment. Every patient doing dialysis at home, rather than in a facility, saves the health system about $30,000 each year. Any fall in home dialysis numbers increases the overall cost of treating kidney failure.

There are currently no incentives for DHBs to maximise the number of patients on home dialysis.

The falling rate of home dialysis is often attributed to increasing patient age and medical co-morbidity, although studies suggest that the majority of patients are still clinically suitable for home dialysis. A more likely reason is the increasing mismatch between patient requirements and the manner in which healthcare providers deliver home dialysis services.\textsuperscript{13} It is, therefore, critical to configure services to optimize patient engagement, especially

\textsuperscript{12} Fortnum D1, Ludlow M, Morton RL. Renal unit characteristics and patient education practices that predict a high prevalence of home-based dialysis in Australia. Nephrology (Carlton). 2014 May 6. doi:10.1111/nep.12274
\textsuperscript{13} Ludlow MJ, Lauder LA, Mathew TH, Hawley CM and Fortnum D. Australian consumer perspectives on dialysis: First national census. Nephrology 2012;17:703-709
immediately before dialysis inception (the “pre-dialysis” period) when they are making key choices.

**Recommended actions**

This issue stems from a lack of national leadership on this issue; the Ministry of Health support for individual DHBs and the national renal leadership body (the National Renal Advisory Board - NRAB) is not enough to get traction on this issue that leads to better outcomes for patients and lower healthcare expenditure. KHNZ therefore recommends:

- The Government set a national target of at least 65% of dialysis patients on a community-based therapy.
- The Ministry of Health actively support the NRAB to develop national practice standards for home dialysis, including staff education on home dialysis to underpin all DHBs having a “Home first policy” consistent with meeting the 65% target.
- The national practice standards ensure that no patient is financially worse off from dialysing at home (see proposal 6 below).

**Estimated cost**

Increasing the rate of home dialysis will reduce costs in the health sector. The costs of the Ministry of Health support would be met by reprioritising existing Ministry of Health baselines.

5. **Improve support for home dialysis patients**

**What is the issue?**

Home dialysis patients take responsibility for their own dialysis and save about $30,000 annually each by not using more expensive hospital based dialysis.

Patients and their carers report that they often feel unsupported and question why in some parts of the country out-of-pocket expenses, from $500 to $1,000 annually depending on the dialysis type, are not reimbursed by their DHB. These expenses relate to increased costs for power, water and travel. Not all patients reside in a DHB that has a renal unit and this complicates the recognition and re-imbursement of these expenses.

**Why is it a problem?**

Failure to reimburse patients for such expenses is a barrier to increasing the rate of home dialysis, and is an issue of equity and fairness. Some DHBs, such as Auckland, reimburse patients while others do not.

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14 CMDHB is currently considering such a proposal. Canterbury and Southern DHBs have practiced a “community only” dialysis policy for over 40 years and do not have facilities for long term hospital dialysis.
There are issues with renal social work skill and capacity across DHBs. Renal social work support is typically – but not always – associated with the discharge of patients after an admission to hospital, but not about how to ensure that the in-community support and resources are present to enable a patient/family to adequately self-manage their condition away from hospital. This compromises the underlying approach to managing ESKD – which is self-management by the patient and their family in the community.

The issues with renal social work support are particularly acute when patients live in a DHB which does not have a renal service. Home dialysis patients need support to continue self-management of their care and achieve optimal independence.

**Recommended Actions**

There is no stock take of policies and practice in terms of reimbursing patient's dialysis costs, and little research on the level and quality of renal social work support for chronic renal patients. The Central Region Renal Network undertook a study of renal social support supports for the central region in 2009/10, and found wide discrepancies in policy and practice across the six represented DHBs, but the study's recommendations were ignored.

KHNZ recommends that:

- The Ministry of Health co-ordinate a stock take of DHB policies to reimburse home dialysis patients for out-of-pocket expenses, and develop policies to ensure that DHBs reimburse home dialysis patients for out of pocket expenses by including these costs in DHBs’ contracts for dialysis services

- The Ministry of Health undertake a study to establish:
  - What support is currently available for dialysis patients and their families?
  - What is national and international best practice for dialysis patients’ support?
  - How can any gaps in service provision be addressed?

- From this study, the Ministry set social work resource standards for DHBs in the Tier 2 Service Specification – Specialist Medical and Surgical Services – Renal Services

**Estimated cost**

The costs of the Ministry of Health stock take and studies would be met by reprioritising existing Ministry of Health baselines.

The ongoing costs of addressing out-of-pocket costs faced by patients will only be known once the stock take is done. The savings from the recommended increase in home dialysis could offset any extra costs.

The ongoing costs of addressing the level and quality of renal social work support will only be known once the recommended study is done. A business case for any funding requirements could be prepared once these costs are known.
6. Access to “Away from home” haemodialysis

What is the issue?

Patients on dialysis cannot take a break from treatment. People on peritoneal dialysis can travel and continue their dialysis while away from home but those on haemodialysis need access to a dialysis machine which is not portable. This presents challenges when patients require dialysis treatment when they travel away from their base unit or home (if on home dialysis) for business or as part of their work. In many cases, this may mean that a patient has to change their job or stop working: neither outcomes are conducive to their full rehabilitation. Improved access to “away from home” dialysis would increase the opportunities for some dialysis patients to get a job.

Carers have access to carer relief but if they are not available to assist with dialysis the patient must have their treatment at the regional hospital dialysis unit. Home dialysis patients have limited access to mobile dialysis units (campervans) or holiday dialysis houses and only a minority of haemodialysis patients can afford to pay for dialysis at units overseas. The majority of patients who wish to travel within New Zealand for a holiday need to have dialysis in the hospital or satellite dialysis unit at the local renal unit. The lack of “away from home” dialysis facilities presents challenges for these patients and their families can lead to carer burnout and depression for haemodialysis patients.

Currently, access to “out of town” dialysis is co-ordinated by the staff at the patient’s base dialysis unit. There are issues with New Zealand renal units’ capacity to accept “out of town” patients and a lack of national co-ordination.

Why is it a problem?

Opportunities for return to work are reduced which affects patients’ self esteem and family income. Return to work is an important part of rehabilitation for dialysis patients. The lack of provision of out of town dialysis means that most haemodialysis patients cannot take up employment that requires travel. If patients and/or carers experience burnout they are likely to revert to more expensive and, for many who live distant from the renal unit, inconvenient, hospital dialysis. Patients report that the inability to have a holiday has a major effect on their quality of life, and can lead to carer burn-out. This matters given the underlying approach of self-management of ESKD in a home or community setting.

Recommended actions

KHNZ recognises that this is a difficult issue, requiring national co-ordination. We recommend that the Ministry of Health, in consultation with the NRAB and KHNZ, develop proposals for the Minister’s consideration on:

• Including provision of facilities for “out of town” and holiday dialysis as part of the standards of dialysis care appended to the Tier 2 Service Specification – Specialist Medical and Surgical Services – Renal Services

• Resourcing some or all dialysis units to have one or two dedicated “out of town” dialysis chairs, depending on the unit size

• Appointment of a national dialysis travel coordinator
**Estimated cost**

The costs of the Ministry of Health developing proposals for improved “out of town” and holiday dialysis services would be met by reprioritising existing Ministry of Health baselines.

The on-going costs of addressing the issues with “out of town” and holiday dialysis will only be known once the recommended analysis is done. A business case for any funding requirements could be prepared once these costs are known.

**7. Improve GP knowledge of management of CKD**

*What is the issue?*

Most CKD is managed in primary care. Most people with CKD do not know they have the condition. Early detection and treatment reduces the important complications of CKD – heart disease, kidney failure and premature death – by about 50%.\(^\text{15}\) Groups at high risk of CKD can be screened with simple blood and urine tests. Most people with CKD do not need to see a specialist but primary care need support from specialist services.

KHNZ has developed a GP Guide for the Management of Chronic kidney Disease\(^\text{16}\) and a number of DHBs have guidelines for patient referral for specialist care but there is currently no national consensus on CKD management. The Ministry of Health, NRAB and primary care stakeholders are working on developing such a national consensus statement. When this is agreed there will be challenges in implementing the proposal and educating primary care practitioners. In particular, there is no national education programme for GPs and practice nurses. There is evidence of patchy performance by primary care in recognition and management of CKD. For example, in a recent Australian study of the management of type 2 diabetes in general practice the finding of proteinuria, a marker of CKD, did not significantly alter patient care.\(^\text{17}\)

*Why is it a problem?*

The underlying philosophy of treating CKD and chronic ESKD will fail to address rising numbers of patients if GPs are ill-equipped to manage renal patients.

*Recommended Actions*

Addressing this issue requires a national, co-ordinated approach. KHNZ recommends that the Ministry of Health develop a proposal for:

- a national education programme on CKD management for primary care.

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\(^\text{16}\) Available at [www.kidneys.co.nz](http://www.kidneys.co.nz)

• adopting and modifying the Kidney Check Australia Taskforce (KCAT) programme\textsuperscript{18} developed by KHA, for use in New Zealand
• resourcing a provider to manage the KCAT programme in New Zealand.

\textit{Estimated cost}

The costs of the Ministry of Health developing proposals for a national education programme on CKD management would be met by reprioritising existing Ministry of Health baselines. The on-going costs of a national education programme will only be known once the recommended analysis is done. A business case for any funding requirements could be prepared once these costs are known.

\textsuperscript{18} Available at http://www.kidney.org.au/HealthProfessionals/KidneyCheckAustraliaTaskforceKCAT/tabid/630/Default.aspx